FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040014

Facility Name: MANORCARE AT SKOKIE

Address: 4660 Old Orchard Rd. (Number) Skokie (City) 60076 (Zip Code)

County: Cook

Telephone Number: 847-676-4800 **Fax #** 847-676-4860

IDPA ID Number: 520886946020

Date of Initial License for Current Owners: 11/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Craig Dekany **Telephone Number:** 419-252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/01 to 05/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazaru

(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	240	1,035	4,392	5,667	8
9	SNF/PED					9
10	ICF	7,445	2,131	19	9,595	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,685	3,166	4,411	15,262	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.67%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
0

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location
Date started 11/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 2,564

Medicare Intermediary CareFirst

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [ ] NO [x]

Tax Year: 12/31/02 Fiscal Year: 5/31/02

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	154,486	10,747	2,651	167,884	919	168,803	(696)	168,107			1
2	Food Purchase		73,124		73,124		73,124		73,124			2
3	Housekeeping	70,544	11,329	1,083	82,956		82,956		82,956			3
4	Laundry	51,390	2,407	1,532	55,329		55,329		55,329			4
5	Heat and Other Utilities			74,808	74,808	4,371	79,179		79,179			5
6	Maintenance	28,644	11,148	24,361	64,153		64,153		64,153			6
7	Other (specify):* Med Waste			1,193	1,193		1,193		1,193			7
8	**TOTAL General Services**	305,064	108,755	105,628	519,447	5,290	524,737	(696)	524,041			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	821,276	100,244	129,195	1,050,715	20,708	1,071,423		1,071,423			10
10a	Therapy	205,793	966	29,679	236,438		236,438		236,438			10a
11	Activities	50,393	3,383	5,259	59,035		59,035		59,035			11
12	Social Services	30,760			30,760		30,760		30,760			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,108,222	104,593	182,133	1,394,948	20,708	1,415,656		1,415,656			16
	C. General Administration											
17	Administrative	64,316		175,235	239,551	(55,833)	183,718		183,718			17
18	Directors Fees											18
19	Professional Services			10,753	10,753	(585)	10,168	(10,168)				19
20	Dues, Fees, Subscriptions & Promotion			88,431	88,431		88,431	(21,205)	67,226			20
21	Clerical & General Office Expenses	182,131	32,694	72,959	287,784	210	287,994	(49,336)	238,658			21
22	Employee Benefits & Payroll Taxes			275,867	275,867	6,763	282,630		282,630			22
23	Inservice Training & Education			455	455		455		455			23
24	Travel and Seminar			8,960	8,960		8,960		8,960			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,872	40,872		40,872		40,872			26
27	Other (specify):*											27
28	**TOTAL General Administration**	246,447	32,694	673,532	952,673	(49,445)	903,228	(80,709)	822,519			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,659,733	246,042	961,293	2,867,068	(23,447)	2,843,621	(81,405)	2,762,216			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MANORCARE AT SKOKIE #0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			288,345	288,345	23,447	311,792		311,792			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes			110,879	110,879		110,879		110,879			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,438	30,438		30,438		30,438			35
36	Other (specify):*											36
37	**TOTAL Ownership**			429,662	429,662	23,447	453,109		453,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,130	15,802	135,932		135,932		135,932			39
40	Barber and Beauty Shops		242	4,637	4,879		4,879		4,879			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,660	30,660		30,660		30,660			42
43	Other (specify):*			59,017	59,017		59,017		59,017			43
44	**TOTAL Special Cost Centers**		120,372	110,116	230,488		230,488		230,488			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,659,733	366,414	1,501,071	3,527,218		3,527,218	(81,405)	3,445,813			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(696)	1		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,195)	21		10
11	Discounts, Allowances, Rebates & Refunds	(1)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,548)	21		13
14	Non-Care Related Interest	(659)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation	(277)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(10,168)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,656)	21		24
25	Fund Raising, Advertising and Promotional	(856)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(20,349)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,405)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,405)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Programs		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MANORCARE AT SKOKIE

ID# 0040014

Report Period Beginning: 06/01/01

Ending: 05/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(696)	0	0	0	0	0	0	0	0	0	0	(696)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(696)	0	0	0	0	0	0	0	0	0	0	(696)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,168)	0	0	0	0	0	0	0	0	0	0	(10,168)	19
20	Fees, Subscriptions & Promotions	(21,205)	0	0	0	0	0	0	0	0	0	0	(21,205)	20
21	Clerical & General Office Expenses	(49,336)	0	0	0	0	0	0	0	0	0	0	(49,336)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(80,709)	0	0	0	0	0	0	0	0	0	0	(80,709)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(81,405)	0	0	0	0	0	0	0	0	0	0	(81,405)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(81,405)	0	0	0	0	0	0	0	0	0	0	(81,405)	45

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, OH			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 175,235	HCR ManorCare, Inc.	100.00%	$ 175,235	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Managemen	14,000	Heartland Mangagement Service	100.00%	14,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 189,235			$ 189,235	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: (419-252-5500
Fax Number: (419-252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	3,274,928	919	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		3,274,928	250	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		3,274,928	4,121	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	3,274,928	17,764	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	3,274,928	2,569	6
7	17	General & Administrative - Direc	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	3,274,928	22,803	7
8	17	General & Administrative - Poole	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	3,274,928	96,599	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		3,274,928	3,484	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		3,274,928	3,279	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		3,274,928	164	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		3,274,928	23,283	12
13										13
14		Interest				12,439,256				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 136,795,596	$ 66,939,331		$ 175,235	25

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2001 report.	$	106,761	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	106,761	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	100,968	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	9,911	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	110,879	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1997	109,878	8
1998	110,145	9
1999	110,271	10
2000	106,761	11
2001	100,968	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE AT SKOKIE COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040014

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE 419-252-5740 FAX #: 419-254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-103-024-0000	See Attached	$ 52,397.44	$ 52,397.44
2.	10-10-103-029-0000	See Attached	$ 191.95	$ 191.95
3.	10-10-103-024-0000	See Attached	$ 52,176.34	$ 52,176.34
4.	10-10-103-029-0000	See Attached	$ 231.78	$ 231.78
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 104,997.51	$ 104,997.51

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,808 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 300,000	1
2					2
3	TOTALS			$ 300,000	3

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	56			1994	$ 1,940,000	$ 48,449		$ 48,449	$	$ 363,885	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					87,385		87,385		487,072	9
10				1995	1,331,819						10
11	Doors/Windows			1996	7,023						11
12	Electrical			1996	4,374						12
13	Professional Services			1996	8,622						13
14	Medical Gas System			1996	3,449						14
15	Replace Water Pump Unit			1996	3,634						15
16	Doors/Hardware			1996	4,847						16
17	Carpeting			1996	2,342						17
18	Medical Gas System			1996	19,419						18
19	Professional Fees			1996	6,529						19
20	Wallcovering			1996	25,335						20
21	Plumbing			1996	60,000						21
22	Remodel OT			1996	1,464						22
23	Remodel Washrooms			1996	20,681						23
24	Electrical			1996	7,291						24
25	HVAC/Ductwork			1996	4,891						25
26	Wall Repairs			1996	1,692						26
27	Doors			1996	1,812						27
28	Landscaping			1997	1,762						28
29	Phone System			1997	2,458						29
30	Wallcoverings			1997	1,502						30
31	HVAC			1997	21,340						31
32	Carpeting			1997	5,314						32
33	Install CATV Jacks			1997	5,548						33
34	Remodel Offices			1997	22,516						34
35	HVAC			1997	8,508						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Repair Walls	1997	$ 1,328	$		$	$	$	37
38	Install New Siding	1997	20,000						38
39	Install Shower Tile	1997	15,817						39
40	Install Ball Valve	1997	1,955						40
41	Kitchen Plumbing	1997	7,446						41
42	Remodeling Tub/Shower	1997	9,300						42
43	Nurse Call Service	1997	1,795						43
44	Lighting	1997	13,266						44
45	Flooring	1997	6,671						45
46	New Siding/Soffit	1997	14,600						46
47	Office Remodeling	1998	6,000						47
48	Toilet Access	1998	1,612						48
49	Soors/Windows	1998	14,763						49
50	Electrical	1998	4,289						50
51	Carpeting	1998	3,457						51
52	Roofing	1998	1,915						52
53	HVAC	1998	11,786						53
54	Painting/Wallcoverings	1998	5,240						54
55	Painting/Wallcovering	1998	2,266						55
56	Developers	1998	5,555						56
57	HVAC	1998	797						57
58	Sign	1998	11,862						58
59	Comm. Edison	1998	2,842						59
60	Painting/Wallcovering	1999	62						60
61	Paving	1998	18,870						61
62	General construction	1999	6,241						62
63	Vinyl Wall Border	1999	191						63
64	Suite Signs	1999	942						64
65	Wallcoverings	1999	3,101						65
66	Wall Borders	1999	1,339						66
67	Vinyl Wallcoverings	1999	512						67
68	Freight	1999	117						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,720,109	$ 135,834		$ 135,834	$	$ 850,957	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 3,720,109	$ 135,834		$ 135,834	$	$ 850,957	1
2	Relaminate Nurse Station	1999	7,015						2
3	Carpet	1999	14,458						3
4	Mag Door Holders	1999	756						4
5	Carpeting	1999	557						5
6	Handrail	2000	5,480						6
7	Border	2000	650						7
8	Molding & Painting	2000	3,958						8
9	Freight Wallcovering	2000	117						9
10	Heating	2000	7,015						10
11	Heritage Corridors	2000	7,618						11
12	Door Frame Protection	2000	741						12
13	Door Hardware	2000	49						13
14	Solarium	2000	3,260						14
15	Vinal Wall Covering, Corner Guards, & Painting	2000	5,772						15
16	Carpet	2000	752						16
17	Freight Carpet	2000	68						17
18	Plumbing Public Restrooms	2000	989						18
19	Plumbing remaining balance	2000	989						19
20	Door Work/Heating	2000	832						20
21	Painting - Exterior Bldg	2000	3,690						21
22	Doors	2000	6,121						22
23	Exterior Renovation	2000	15,230						23
24	Concrete	2000	2,570						24
25	Carpeting & Sheet Vinyl	2000	28,655						25
26	Carpet - O/T Room	2000	3,239						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,840,691	$ 135,834		$ 135,834	$	$ 850,957	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,268,880	$ 152,511	$ 152,511	$		$ 1,099,776	71
72	Current Year Purchases	15,107						72
73	Fully Depreciated Assets							73
74	H/O Allocation			23,447	23,447			74
75	TOTALS	$ 1,283,987	$ 152,511	$ 175,958	$ 23,447		$ 1,099,776	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,424,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 288,345	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 311,792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 23,447	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,950,733	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO

16. Rental Amount for movable equipment: $ 30,438 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds., Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3025	hrs	$ 82,859	273	$ 6,826	$ 558	3,298	$ 90,243	1
2	Licensed Speech and Language Development Therapist	10a	1028	hrs	28,151	99	2,474		1,127	30,625	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3461	hrs	94,783	815	20,379	408	4,276	115,570	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				120,130		120,130	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S X-Ray & Lab	39,3					15,802			15,802	13
14	TOTAL				$ 205,793	1,187	$ 45,481	$ 121,096	8,701	$ 372,370	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number MANORCARE AT SKOKIE **#** 0040014 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,941	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,206)	541,184		3
4	Supply Inventory (priced at)	5,070		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,831		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 556,026	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,000		13
14	Buildings, at Historical Cost	3,840,691		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,283,987		16
17	Accumulated Depreciation (book methods)	(1,950,733)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,473,945	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,029,971	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,462	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,682		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,968		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	64,809		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 328,921	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 328,921	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,701,050	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,029,971	$	48

***(See instructions.)**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,972,030	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,972,030	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(660,476)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (660,476)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	389,496	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 389,496	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,701,050	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 2,540,141	1
2	Discounts and Allowances for all Level	(365,141)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,175,000	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	556,617	6
7	Oxygen	6,588	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 563,205	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop	796	12
13	Barber and Beauty Care	5,102	13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,305	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	6,005	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	4,476	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 124,684	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	659	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 659	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		3,194	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,866,742	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	519,447	31
32	Health Care	1,394,948	32
33	General Administratior	952,673	33
	B. Capital Expense		
34	Ownership	429,662	34
	C. Ancillary Expense		
35	Special Cost Centers	230,488	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,527,218	40
41	**Income before Income Taxes (line 30 minus line 40)****	(660,476)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (660,476)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,030	2,160	$ 64,901	$ 30.05	1
2	Assistant Director of Nursing	1,177	1,252	31,679	25.30	2
3	Registered Nurses	9,884	10,515	244,883	23.29	3
4	Licensed Practical Nurses	7,415	7,888	145,618	18.46	4
5	Nurse Aides & Orderlies	27,915	29,695	311,999	10.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,166	7,514	205,793	27.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	4,534	4,823	50,393	10.45	9
10	Activity Assistants					10
11	Social Service Worker	1,781	1,896	30,760	16.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,493	15,256	154,486	10.13	15
16	Dishwashers					16
17	Maintenance Worker	3,272	3,276	28,644	8.74	17
18	Housekeepers	6,701	7,124	70,544	9.90	18
19	Laundry	5,199	5,530	51,390	9.29	19
20	Administrator	2,150	2,080	64,316	30.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,840	11,789	182,131	15.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,116	2,249	22,196	9.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,673	113,047	$ 1,659,733 *	$ 14.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	5,9,3	36
37	Medical Records Consultant	Monthly	375	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Admin. Consultant	Monthly	210	5,21,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,585		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,154	$ 96,746	5,10,3	50
51	Licensed Practical Nurses	1,107	20,434	5,10,3	51
52	Nurse Aides	221	2,325	5,10,3	52
53	TOTAL (lines 50 - 52)	5,482	$ 119,505		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Perl	Administrator	0	$ 64,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 64,316

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 175,235
TOTAL (agree to Schedule V, line 17, col. 3)	$ 175,235
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Purcell & Wardrope Chargered	Legal Fees	$ 10,235
Ann Krug	Med Rec Consult.	375
Weissman Group	Admin.	210
Record Copy Services	Legal Fees	(67)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,753

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,152
Unemployment Compensation Insurance	17,982
FICA Taxes	115,894
Employee Health Insurance	90,084
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	3,291
401K	3,838
Other Employee Benefits	1,781
Disability Payments	1,692
Employee Uniforms	1,151
P/R O/H	2
Home Office Allocation	6,763
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,630

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 621
Advertising: Employee Recruitment	62,254
Health Care Worker Background Check	889
(Indicate # of checks performed 36)	
Dues & Subscriptions	1,585
Assoc. Dues Admin	2,733
Advertising	10,367
Public Relations	9,982
Less: Non-allowble Lobbying Expense	(856)
Less: Public Relations Expense	(9,982)
Non-allowable advertising	(10,367)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 67,226

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,960
Includes travel expenses to the home	
office in Toledo, Ohio for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,960

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MANORCARE AT SKOKIE # 0040014 Report Period Beginning: 06/01/01 Ending: 05/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **IHCA $2,733**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **Yes** If YES, have these cost
been properly adjusted out of the cost report **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **No** If YES, what is the capacity

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perio

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **15,574** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **No**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **30,660**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **No** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **Yes**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **N/A** Has any meal income been offset agains
related costs? **No** Indicate the amount $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **Yes**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **No** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **N/A**
d. Have vehicle usage logs been maintained **N/A**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report
g. Does the facility transport residents to and from day training No
Indicate the amount of income earned from providing suc
transportation during this reporting period $

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **Yes**
Attach invoices and a summary of services for all architect and appraisal fee